STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00098314 and IN00097893. Complaint IN00097893: Substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F323. Complaint IN00098314: Substantiated, No deficiencies related to the allegation are cited. Survey dates: November 1, 2, 3, 4, 7, 9, 10, 2011 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Survey team: Diane Hancock, RN- TC Amy Wininger, RN Vickie Ellis, RN 11/2, 11/3, 11/7, 11/9, 11/10 Barbara Fowler, RN 11/4, 11/7, 11/9, 11/10 Census bed type: SNF 9 SNF/NF 85 Total 94	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Census payor type: Medicare 12 Medicaid 74 Other 8 Total 94 Sample: 19 Supplemental Sample: 15 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed on November 17,2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure the physician was notified for a resident's continued pain and inability to bear weight after an unwitnessed fall, for 1 of 19 residents reviewed for notification of the physician, in the sample of 19. (Resident B)	F0157	F157Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*Resident B-MD priovided documentation of proof of notification dated 6/25/11 at 4:30am. The following was reported to MD "Left side of hip-L leg is shorter than other leg, patient can't lift leg. Painful when	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: The clinical record of Resident B was reviewed on 11/02/11 at 10:45 A.M. The clinical record indicated the diagnoses included, but were not limited to, dementia and repair of left hip fracture. During the initial tour, on 11/01/11 at 11:00 A.M., the Social Worker identified Resident B as having experienced falls, utilized bed and chair alarms, and was not interviewable. Resident B was observed, at that time, lying in bed with a mat on the floor. The MDS [Minimum Data Set Assessment], dated 04/11/11, indicated Resident B required extensive assist of one person for transfers and ambulation. The History and Physical, dated 06/27/11, indicated, "History of Present Illness General...X-rays were ordered [on 6/25/11]...and results were faxed from [name of company]. X-rays were normal. Today Iam [sic] here to see the patient patient [sic] unable to weight bear, and on reviewing the x-ray, the x-ray faxed where [sic] from April of this year [not from 6/25/11]. Call was placed to [name of company] and current x-ray was obtained which showed left femoral neck impacted		moved. VS Stable"Per request of ISDH Surveyor, Diane Hancock, the supportive documentation (that was completed on 6/25/11 and 6/26/11) was scanned to surveyor's email address for proof of notification on 11/10/11 at 11:55am.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*All residents with falls are reviewed by IDT team to ensure MD is notified in a timely manner.Measures put into place or systemic changes made to ensure deficient practice does not recur:*Licensed nurses inserviced and post tested on the policy regarding physician notification by the Director of Nursing by 12//1/11.*IDT team will review all falls to ensure MD is notified promptly of falls.*Director of Nursing/designee will be notified of falls on weekends by charge nurses and ensure prompt notification to the physicians.Corrective actions will be monitored to ensure the deficient practice will not recur:*The IDT team will monitor Moinday through Friday with the use of CQI Fall Management Tool for 3 months and weekly for 3 months. *Director of Nursing/designee will complete CQI Fall Management Tool.*Results from the audits will be reviewed during monthly CQI committee meetings for 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fracture..." A Nurse's Note, dated 06/25/11 at 1330 [1:30 P.M.] indicated, "Call placed to office of [name of physician] updating nurse that x-rays show neg [negative] for fx [fracture]." An x-ray was done on 6/25/11. A Nurse's Note, dated 06/25/11 at 1400 [2:00 P.M.], indicated "...cont [continue] to c/o [complain of] pain in Left upper thigh/hip area-no bruising noted there-no rotation-guarded movement of left leg...Medicated for pain.." A Nurse's Note, dated 06/26/11 at 1300 [1:00 P.M.], indicated, "...not bearing much wt [weight] on left leg-leaning on staff for transfers-medicated for pain about 1030...not propelling self about as usual..." A Nurse's Note, dated 06/26/11 at 2130 [9:30 P.M.], indicated, "Still c/o [complain of] pain left hip...Wife voiced a lot of anxiety and concern that [Resident B] may actually have a fractured left hip. Rec'd [received] Lortab for pain..." A Nurse's Note, dated 06/27/11 at 1200 [12:00 P.M.], indicated, "Cont to c/o increased discomfort left hip with movement not bearing full wt. with		months. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfers..." The Nurse's Notes from 06/25/11 at 1330 through 06/27/11 lacked any documentation of the physician being notified of Resident B's continued pain and lack of ability to bear weight as usual. During the exit interview on 11/10/11 at 4:00 P.M., the DoN indicated she was "not able to find where the physician was notified over the weekend that [Resident B] was having increased pain and not able to bear weight." During the exit interview, the DoN phoned the physician and indicated, "[name of physician] would call back if [name of physician] finds it." At the conclusion of the exit interview, the physician had not called back to facility. The policy and procedure for Resident Change of Condition, provided by the DoN on 11/10/11 at 2:10 P.M., indicated, "Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician...and that appropriate, timely, and effective intervention occurs...Procedure: 2. Acute Medical Change a. any sudden or serious change in a resident's condition manifested by a marked change in physical...behavior will be communicated to the physician..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This federal tag relates to complaint number IN00097893. 3.1-5(a)(3)			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure 1 of 2 sampled residents with breakaway lap buddies, in the sample of 19, was free of physical restraints, in that the resident could not release the lap buddy on command and was restrained by the device. (Resident #80) Finding includes: Resident #80's clinical record was reviewed on 11/7/11 at 4:20 p.m. The resident's diagnoses included, but were not limited to, dementia, depression, anxiety, and aphasia. Resident #80 had an annual assessment, dated 3/2/11 and a quarterly assessment, dated 10/16/11, indicating the resident	F0221	F221Corrective action that will be accomplished for those residents found to have been affected by the deficient practice.*Resident #80 was re-assessed by the IDT on 11/16/11 for physical restraint usage. A physician order was obtained for a break away lap buddy on 11/16/11.Care plan and assignment sheet was updated.*Licensed nurses were inserviced on the Policy and Procedure for Physical Restraint by the Director of Nursing by 12/1/11.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*Residents who utilize restraints have the potential to be affected.*All residents with lap buddies, self-releasing belts and alarmed belts were reassessed by the Director of Nursing/Assistant Director of	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	required extensive assistance of two for transfers and was unable to ambulate. The resident had a care plan, dated 6/3/11, indicating the resident was at risk for falls. Approaches include, but were not limited to, the following: -call light in reach -non skid footwear -personal items in reach -therapy screen -7/7/11 low Broda chair -7/7/11 low bed -7/7/11 bed against wall -7/25/11 pressure alarm to bed and w/c (Broda) -9/20/11 walk to dine for meals -7/27/11 break away lap buddy The clinical record included an Occupational Therapy Progress Report, dated 7/15/11 at 3:23 p.m. The report included, but was not limited to, the following remarks: "Patient's break away lap buddy is not being utilized as restraint only positioning to decrease forward flexion. Patient is able to self release break away lap buddy independently and stand as desired." Resident #80 was observed in the dining/activity room, during the lunch meal on 11/7/11 at 12:15 p.m., to be in a Broda type wheelchair with the lap buddy		Nursing.*Licensed nurses were inserviced on the Policy and Procedure for Physical Restraint.*Nurse consultant inserviced the Interdisiplinary team on restraint assessment and documentation on 11/28/11.Measures put into place or systemic changes made to ensure deficient practice does not recur:*Residents are assessed upon admission, quarterly and upon significant change for restraint usage.*All residents with lap buddies, self releasing belts and alarm belts were reassessed by the Director of Nursing/Assistant Director of Nursing.*Residents with lap buddies, self releasing belts and alarm belts will be reviewed monthly to ensure appropriateness.*Interdisiplinary team will review residents with restraints monthly to ensure appropriateness and plans for restraint reduction.Corrective actions will be monitored to ensure the deficient practice will not recur:*The Interdisiplinary team will monitor residents that have a change in condition that will require a new assessment 5 days a week for 3 months..*The Director of Nursing will complete a restraint CQI tool which will be utilized weekly times 4 and monthly times 2 and quarterly therafter.*Results from audits will be reviewed during monthly CQI committee meeting. If a threshold of 95% is not met,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in place. The resident was in the dining/activity room on 11/7/11 at 4:15 p.m., also in the Broda chair with the lap buddy in place across the front of the wheelchair on his lap. The Director of Nurses and the Rehabilitation Director were interviewed on 11/9/11 at 4:20 p.m. They indicated the lap buddy was attached with Velcro and would break away if the resident stood up. They indicated it had worked very well to keep the resident from falling. They indicated it was there to keep the resident's hips back and prevent leaning forward. They indicated he could stand up if he wanted to stand up. Resident #80 was observed on 11/10/11 at 9:10 a.m. He was seated in the Broda chair in the dining/activity room. The lap buddy was strapped in place to the wheelchair using Velcro straps and it was positioned across his lap. The resident was requested to release the lap buddy and stand up, in the presence of the Unit Manager. He was unable, cognitively, to understand. He fidgeted with his clothing. He was unable to release the lap buddy on command. 3.1-3(w) 3.1-26(o)		an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, and interview, the facility failed to ensure 1 of 1 residents reviewed for allegations of verbal abuse, in the sample of 19, was free of verbal abuse, in that the facility investigation indicated Resident #85 experienced verbal abuse from a staff member. Finding includes: The DoN [Director of Nursing] provided a facility investigation of staff to resident abuse on 11/7/11 at 5:30 P.M. The facility investigation for an employee to resident verbal abuse allegation on 10/19/11 included, but was not limited to, an Employee Communication Form, dated 10/19/11 indicated, "Employer Statement...CNA [Certified Nursing Assistant] made statement to other CNA in front of resident [Resident #85] 'She is a mean old lady'... Employee [CNA #1] admitted that she made statement in front	F0223	F223The facility submits a plan of correction for the following deficiency despite the facility maintaining substantial compliance.It is the practice of this provider to ensure that the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.Corrective action that will be accomplished for those resident found to be affected by the deficient practice:* CNA #1 was immediately suspended pending investigation.* CNA #1 was terminated after a completion of investigation.* Facility monitored resident #85 for any adverse affects to psychosocial well being. No psychosocial issues, no adverse affects and emotional well being stable.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*Residents residing in the facility have the potential to be affected.* Residents were questioned within 24 hours of incident to identify if there were	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of resident [Resident #85]..." The facility investigation included a Fax Incident Reporting Form, which indicated, "...Preventative Measures Taken: [CNA #1] was suspended immediately and sent home. Employee was terminated from employment on 10/20/11." During an interview with the DoN on 11/07/11 at 4:40 P.M., she indicated, "[CNA #1] sat right next to me in abuse inservice and then the very next day she was verbally abusive to [Resident #85]..." The Abuse Prohibition, Reporting, and Investigation Policy and Procedure provided by the DoN [Director of Nursing] 11/1/11 at 10:30 A.M., indicated, "It is the policy of [name of corporation] to protect residents from abuse, including ...verbal abuse..." The policy further indicated, "...Definition of Abuse...Verbal Abuse...derogatory terms to residents...within their hearing distance, regardless of their...ability to comprehend..." 3.1-27(b)		any other instances.Measures put into place or systemic changes made to ensure deficient practice does not recur:*All staff inserviced on abuse policy on 10/11/11, 10/13/11, 10/15/11 and 10/16/11.Corrective Actions will be monitored to ensure the deficient practice will not recur:*Participation by staff in abuse inservice training to be reviewed by CQI Committee in CQI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident who had a catheter was provided services to prevent urinary tract infections, in that Resident D experienced having a Suprapubic catheter drainage bag and tubing held above the level of the bladder, for 1 of 2 residents reviewed for suprapubic catheters in a sample of 19. Finding includes: Resident D was identified on the initial tour of the facility on 11/01/11, at 11:00 A.M., by LPN #1, as having a suprapubic catheter, requiring assistance with activities of daily living, and being cognitively impaired. Resident D was observed at that time to be sitting in a wheelchair. The clinical record of Resident D was reviewed on 11/03/11 at 11:30 A.M. The Resident's diagnoses included, but were not limited to, Right Ureteral Stone	F0315	F315Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*Resident D-drainage bag was immediately assessed for placement and was found on the bottom rung of the side rail with the side rail in the down position. *The catheter bag was inside of a dignity cover and was lower than the level of the bladder.*The resident is non compliant with moving the catheter bag. Resident was placed on 15 minute checks to ensure the bag is below the level of the bladder.*The resident was educated on keeping the catheter bag below the level of the bladder.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*All residents with catheters were immediately assessed for positioning of drainage bag to ensure the bag was below bladder level.Measures put into place or systemic changes made to ensure deficient practice does not recur:*The nursing staff was	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with Hydroureternephrosis and Major Depressive Disorder. A Physician's telephone order, dated 11/5/11 at 2:45 P.M., indicated, "Primaxin [an antibiotic] q [every] 6 [six] hours IV [intravenously] X [times] 10 [ten days]...infection to urine." The November 2011 Physician's Recap included orders for, "...Suprapubic cath [catheter]...Drain bag...as directed on while in bed..." A care plan, dated 05/05/11, indicated "Resident requires a suprapubic catheter" with interventions which included, but were not limited to, "...Position bag below level of bladder..." On 11/07/11 at 11:15 A.M., Resident D was observed lying in bed with the head of bed elevated. At that time, the siderail on the right side of the bed was observed in the up position. The pelvic area of Resident D was observed to be located in the lower half of the bed. The suprapubic catheter drainage bag was observed to be hanging on the second rung of the siderail located on the upper half of the bed. On 11/07/11 at 11:30 A.M., LPN #1 was		inserviced on proper placement of catheter drainage bags by the Director of Nursing by 12/1/11..*The Director of Nursing or designee will do rounds to ensure placement of catheter drainage bags and specifically look at Resident D's catheter bag placement 2 times a week for 4 weeks then once a week for 8 weeks.*Advised Resident D of correct placement of catheter drainage bag and health risks due to improper placement.*CNA assignment sheets have been updated on residents with catheters to check catheter bag placement.Corrective actions will be monitored to ensure the deficient practice will not recur:*Results of the weekly audits will be reviewed by the Interdisiplinary team.*The Director of Nursing/deignee will audit placement of catheter drainage bags 2 times a week for 4 weeks then once a week for 8 weeks.*Results from audits will be reviewed at the monthly CQI commitee meetings. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed to remove the drainage bag from the siderail, place the drainage bag in a privacy bag, and return the drainage bag to the first rung of the siderail. During an interview with the DoN [Director of Nursing] on 11/9/11 at 2:00 P.M., she indicated, "The bag should be placed below the bladder." The Indiana State Department of Health, Core Curriculum, for Nurse Aide training, dated July 1998, included: "5. The CNA's should: a. Keep drainage bag below level of bladder to allow gravity flow... e. Consider urinary drainage system whenever moving or transferring resident." 3.1-41(a)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure 1 of 9 residents reviewed for falls, in the total sample of 19, was provided assistance devices identified by the plan	F0323	F323Re: FallsCorrective action that will be accomplished for those residents found to have been affected by the deficient practice.*Resident B's fall care plan was reviewed and revised as	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of care to prevent falls, in that the resident had the wrong alarm in place when he experienced a fall that resulted in a fractured left hip. (Resident B) B. Based on observation, interview and record review, the facility failed to ensure 2 of 8 sampled residents reviewed for elopement risk, in the sample of 19, received supervision and assistance to prevent elopement from a locked unit and/or the facility building, in that Resident F left the building twice without staff knowing and Resident G left the locked Alzheimer's Unit once without staff knowing. Findings include: A.1. During the initial tour, on 11/01/11 at 11:00 A.M., the Social Worker identified Resident B had experienced falls, utilized bed and chair alarms, and was not interviewable. Resident B was observed at that time, lying in bed with a mat on the floor. The clinical record of Resident B was reviewed on 11/02/11 at 10:45 A.M. The record indicated the diagnoses included, but were not limited to, Dementia and Left hip fracture repair. An Interdisciplinary Team [IDT] Progress		indicated.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*All residents have the potential to be affected.*Residents are assessed upon admission, quarterly, annually and with significant change of condition for fall risk.Measures put into place or systemic changes made to ensure deficient practice does not recur:*A root cause analysis will be performed by the Interdisiplinary Team after each fall to determine causative factor. Interventions will be implemented based on the root cause analysis.*CNA assignment sheets and care plans will be updated to reflect the new interventions.*The Interdisiplinary Team will be re-educated by the Nurse consultant on root cause analysis on 11/28/11.*Charge nurses will perform rounds no less than twice per shift to ensure compliance with fall interventions.*The Director of Nursing or designee will perform rounds 5 times per week for one month and 3 times per week for 2 months to monitor for residents at fall risk and compliance with interventions.Corrective actions will be monitored to ensure the deficient practice will not recur:*The Director of Nursing will bring results of the daily/weekly rounds to the CQI meeting for the Interdisiplinary Team to review. If a threshold of 95% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Note, dated 04/06/11, no time, indicated, " reported fall 04/05/11...Fall not witnessed...Res [Resident]states that he got up and put self back to bed. Res c/o [complain of] hip pain...Immediate intervention was to place bed alarm..." An IDT Progress Note, dated 04/12/11 no time, indicated, "Res returned...with new dx [diagnosis] of Right subtrochanteric fx [fracture]...now utilizes bed and w/c [wheelchair] and pad alarms to promote safety and discourage unassisted transfers." A physician's order, also dated 4/12/11, indicated a pressure alarm was to be used on the bed. A Care Plan, dated 04/14/11, indicated Resident B "is at risk for fall..." with interventions that included, but were not limited to, "alarm to bed." A Nurse's Note dated 06/25/11 at 0315 [3:15 A.M.] indicated, "...Resident lying on floor on left side of body...Pull alarm on res was not going off. Found gown in floor along with pull alarm in [sic] floor..." A Fall Circumstance Report, dated 06/25/11 at 0315, indicated, "...heard alarm (roomates [sic] alarm)...pull alarm off in [sic] floor..."		achieved, an action plan will be developed to ensure compliance.Re: ElopementCorrective action that will be accomplished for those residents found to have been affected by the deficient practice.*Resident F was immediately assessed and placed on one on one supervision while up from bed and 15 minute checks with bed alarm while in bed. *Resident G was immediately assisted back from Unit 1 to the Alzheimer's Unit and placed on 15 minute checks for 72 hours with no other exit seeking behaviors.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*Residents are assessed upon admission, quarterly, annual and with significant changes in condition for elopement risk.*An audit was completed to assure a picture profile of all elopement risk residents were present on each unit.*Electronic monitoring bracelets are in place on identified residents and date is current.*Placement and function checked each shift by charge nurse.*Signs were posted on all exits and Alzheimer's Unit doors informing visitors and family members to not let residents off of the Unit.Measures put into place or systemic changes made to ensure deficient practice does not recur:*An electronic monitoring alarm is being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An IDT Progress Note, dated 06/25/11, no time, indicated, "...will replace tab alarm with pressure alarm in bed..." During an interview on 11/10/11 at 3:00 P.M., with the DoN, she indicated that Resident B "should have had a pressure pad alarm and he had a tabs alarm when he fell from bed and fractured his left hip." B.1. Resident F's clinical record was reviewed on 11/9/11 at 11:00 a.m. The resident had an Elopement Risk		installed on the Alzhemeiner's unit door that leads to the other nursing units in the facility. The equipment has been ordered. Installation will be done immediately after receiving delivery of the system hardware.*All exit doors have had a new alarm installed on 11/22/11that sounds at each nurses station when the panic bar is pushed on any exit door. This alarm will sound for the 15 second delay before the door opens. When the door is opened without the use of the key pad, the alarm will sound with an even louder tone.Corrective actions will be monitored to ensure the deficient practice will not recur:* Maintenance staff will check the exit doors and the entrance door to the Alzheimers Unit 5 days a week for three months and weekly for 9 months to ensure proper functioning.*CQI tool for Elopement will be completed once a week for 4 weeks and twice a month for 3 months to ensure compliance for all residents who are at risk for elopement.*Results of the audits will be reviewed during monthly CQI committee meetings. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assessment, dated 6/16/11, indicating the resident was at risk for elopement and had been assigned a security bracelet. The resident had a care plan, dated 6/17/11, for elopement risk. The care plan indicated the resident exited the building on 7/31/11 and 8/27/11. Interventions included, but were not limited to, the following: -Diversional activity if resident is exit seeking-Electronic monitoring bracelet, check function/placement every shift -Involve in group activities of choice -placed on 15 minute checks 7/31/11 -checked wanderguard 7/31/11 -checked doors 7/31/11 -1 on 1 supervision when [up] 8/27/11 -[check] function/placement q shift 8/27/11 -15 min [check] while in bed 8/27/11 -w/c in hallway while in bed 8/27/11 -when [up] go to cottage for programming 8/27/11 Nurses' notes included, but were not limited to, the following: 7/31/11 12:50 p.m. "Reported to this nurse per [name of LPN] that res. was sitting below w/c [wheelchair] ramp in the back parking lot-wanderguard in place [and] in working order - immediately assisted into facility and reported to [name] Social Services [and] [name]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON [Director of Nurses] - Back door not functioning properly - immediately reported to maintenance - BP [blood pressure] 114/68 T [temperature] 97.8 R [respirations] 20 O2 sat [oxygen saturation] 90% on room air - res. placed on 15 min checks. Res. observed in activity room @ 12:40 and heard talking in hallway outside breakroom by housekeepers @ lunch. Dr. [name] notified of occurrence." 8/27/11 12:15 p.m. "Resident outside in parking lot - Last checked @ 1200 - was in Activity Rm. [room] drinking coffee -witnessed per [name] Activity Director [and] [name] Restorative aide - Wanderguard in place on w/c [and] in working order - res. still able to exit facility. - immediately placed one on one - [name] ADON [assistant director of nurses] notified of elopement - Dr. [name] notified. Niece [name] notified of occurrence." IDT [Interdisciplinary Team Progress Notes] notes included, but were not limited to, the following: 8/1/11 [no time] "IDT behavior: Resident exited the building on 7/31/11. Statements from staff states he was last seen at 12:45 p.m. Resident was brought back into facility at 12:50 p.m. by nursing staff. residents vitals taken at this time...Resident placed on 15 min. checks.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	MD, family notified. Wanderguard in place and working. door alarm did not sound when resident exited building. Resident shows no psychosocial distress or physical injury related to being outside. Door was under consistent supervision. Wanderguard called. Immediate intervention was to fix doors. All resident was accounted for, [sic] all doors were checked along [with] all residents who have wanderguards...all are working." 8/29/11 [no time] "IDT this date R/T [related to] resident exited building on 8/27/11 @12:00 N [noon] (approx) [approximately] was last seen in activity room at 12:00 N was found out side at 12:10 p by Activity Assistant. Res. propels self in w.c. and went across parking lot. Res. was brought back into facility by [name] Activity Director. Was accessed [sic] by charge nurse found to have no injury and VS [vital signs] in normal limits...Res. returned at 12:10 to room and was placed on 1 on 1 supervision with ADNS [assistant director of nursing services]. Res. is unable to ambulate and cannot get out of bed without assistance. Res. has alarm pressure pad while in bed. When [up] in wheelchair has wanderguard on at all times. When res. gets [up] from bed will be 1 on 1 monitored until is taken to secure unit. While in secure unit will remain 1 on 1. Labs were ordered by MD,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with results being DX [diagnosed] as UTI [Urinary Tract Infection] - Res. placed on Bactrim DS [antibiotic]...Dr. [name] order that pt. may go to Acute Care Behavior for wandering exit seeking behavior..." The Director of Nurses [DoN] was interviewed, on 11/9/11 at 3:09 p.m., regarding the elopements of the resident. She indicated the elopements were investigated and the facility could not figure out how he got out the door. The wanderguard worked every time it was tested. The wanderguard company did reset the sensitivity after the first elopement. She indicated it was the same weekend staff and the same time of day both times. She indicated a consultant attempted to get through the doors and down the ramp while in a wheelchair and had difficulty. According to the DoN, no one admitted to hearing an alarm on either day. On 11/10/11 at 9:30 a.m., the DoN was queried regarding the wanderguard and how the wanderguard system worked, i.e. how the wanderguard could be turned off if a resident exited the door. At 10:10 a.m. on 11/10/11, the Administrator and DoN indicated the following regarding the current wanderguard system: When a resident with a wanderguard bracelet on approaches a wanderguarded			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	door and gets within 3 feet of the door, the door locks down and an alarm goes off. If a staff person, or a visitor keys in the code into the key pad by the door, the door stays locked, unless the bar on the door is pushed for 15 seconds. If the bar is pushed for 15 seconds, a low beeping sound occurs and the door opens. If a wanderguarded resident goes through the door, a louder alarm occurs. According to the Administrator, who was not at the facility at the time of the events, a loud alarm should have occurred. According to the DoN, no one heard an alarm, according to statements taken at the time of the events. Review of 15 minute check documentation indicated the resident was observed at 12:00 noon by a facility nurse and was found outside in the parking lot of an apartment complex across a dead end street at 12:15 p.m., on 8/27/11. B.2. Resident G's clinical record was reviewed on 11/3/11 at 11:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia, Alzheimer's disease, hypertension, and reflux. The resident had a care plan, dated 1/3/11, for being at risk for elopement due to dementia and wandering. Approaches			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but were not limited to, the following: -Electronic monitoring bracelet, check function/placement every shift -Involve in group activities of choice -Diversional activity if resident is exit seeking -Observe whereabouts The resident had a care plan, dated 9/28/11, for requiring a secured unit related to diagnosis of Alzheimer's or dementia. The goal was for the resident to remain in a safe environment. The approach was for the resident to reside in Auguste's Cottage [the name of the facility's Alzheimer's Dementia unit]. Nurses' notes included, but were not limited to, the following: 9/23/11 2000 [8:00 p.m.] "Exit seeking X 2. Easily redirected [with] 1-1 Compliant [with] care." 9/24/11 1405 [2:05 p.m.] "Continues in et out of others rooms pushing linen carts opening close to more easily redirected..." 9/25/11 0200 [2:00 a.m.] Res. [up] wandering in et out of others rooms, pushing carts about refuses to go to bed." 9/26/11 2000 [8:00 p.m.] Cont. [with] wandering [without] agenda. [up] et [down] hallway pushing barrels of linen. In et out of rooms. Easily redirected..." 9/27/11 2000 "Cont [continues] [with]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wandering. Easily redirected..." 10/3/11 1400 [2:00 p.m.] "Res found walking down F hall station 1 [outside of secured unit on a unit on the other side of the building] brought back to unit easily secure care R [right] ankle in place et functioning 15 min [checks] started." On 11/3/11 at 3:10 p.m., Resident G was observed following a physical therapist, who was walking with another resident towards the door exiting the Alzheimer's Dementia Unit. As the resident approached the door, LPN #3 observed the resident and directed him away from the door. The Director of Nursing [DoN] was interviewed, on 11/4/11 at 3:45 p.m., and indicated she was unaware of the resident having wandered off the unit. She indicated the Unit Manager may have taken care of the issue. The DoN and Assistant Director of Nursing [ADoN] indicated, at that time, the wanderguard alarm was not configured to alarm when a resident went through the Alzheimer's Unit doors. The unit was secured due to the use of a key pad to unlock the doors. The doors exiting the facility to the outside were controlled by the wanderguard. They indicated the resident would had to have followed someone out.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An IDT [Interdisciplinary Team progress note] note, dated 11/4/11 [no time], indicated the following: "IDT this date R/T [related to] resident walked off unit on 10/03/11, was found just past nurses station on station I. Restorative aide, [name] took hand of resident and walked with him back to unit. Aide reported to [name], Charge Nurse who placed resident on supervision and focus charting for 3 days. Res. was on 15 min [checks] with no other episodes of exit seeking. Team recommends inservice of all Dietary/Housekeeping/Laundry/Therapy, clinical staff on ensuring no resident follows them when exit the cottage [Alzheimer's Dementia Unit]...team recommends sign to be placed on both sides of door stating - 'Attention For safety of our residents please make sure door shuts securely. Never allow a resident to exit cottage with you.'" This federal tag relates to complaint number IN00097893. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based upon observation, interview and record review, the facility failed to ensure fast acting insulin was given within the accepted protocol of 5-10 minutes before a scheduled meal, for 1 of 2 residents observed receiving insulin. (Resident D) Finding includes: 1. During the observation of the medication pass on 11/07/11 at 11:15 A.M., LPN #1 was observed to prepare and administer medications for Resident D. LPN #1 administered Novolog [a fast acting insulin] 20 units subcutaneously to Resident D at 11:25 A.M. Resident D had a cheese sandwich served at 1:10 p.m., on 11/7/11 and received the rest of her meal at 1:21 p.m. The clinical record of Resident D was reviewed on 11/3/11 at 11:30 A.M. The November 2011 Physician's Order recap included, but was not limited to, orders for, "...Novolog 100/ml [milliliters] inj [injectable] 20 [twenty] units sub-q [subcutaneous] 3 [three] times daily before meals.." The Nursing 2011 Drug Handbook, page	F0333	F333Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*LPN#1 was inserviced immediately by Director of Nursing on accepted protocol on Novolog administration in regards to mealtimes.Residents identified having potential to be affected by the same deficient practice and coorective action taken:*All residents receiving insulin injections have the potential to be affected.*Medication audit performed to identify other fast acting insulins by Director of Nursing/designee.Measures put into place or systemic changes made to ensure deficient practice does not recur:*Licensed nurses inserviced on accepted protocols on insulin injections in regards to times given by Director of Nursing by 12/1/11.*Director of Nursing or designee will observe administration of Novolog to ensure meal/snack is given within 5-10 minutes 3 times per week for 4 weeks and weekly for 5 months. Snacks will be given at time of injection if meal is going to be consumed within 5-10 minutes.*All fast acting insulins have been identified and are given per manufacturer's intructions.Corrective actions will be monitored to ensure the deficient practice will not recur:*Director of Nursing or	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1064, reviewed on 11/09/11 at 9:12 A.M., obtained at the nurses station used by LPN #1, indicated for "...Novolog...Indications & Dosages...Give 5-10 minutes before start of meal...". During an interview with the DoN [Director of Nursing] on 11/09/11 at 9:30 A.M., she indicated, Novolog administration "depends on Doctor's order, ...usually an hour before meals." The policy and procedure for Medication Administration Guidelines, provided by the DoN 11/09/11 at 10:20 A.M., indicated, "Purpose: To ensure that: the resident gets the right medication at the right time...Procedure:...Administering medications too early...is considered a medication error..." 3.1-48(c)(2)		designee will bring results of observations to monthly CQI meeting for Interdisiplinary Team to review. If threshold of 95% is noy met an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure staffing information was posted on a daily basis, for 4 of 4 days the staffing posting was reviewed. This had the potential to affect all residents and/or their families who reside in the facility census of 94.	F0356	F356Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*No residents were found to be affected by this deficient practice.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*No	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The posting for daily staffing was observed and reviewed on 11/01/11 at 10:20 A.M., on 11/02/11 at 8:30 A.M. and on 11/03/11 at 9:05 A.M. to be dated 10/28/11. The posting for daily staffing was observed and reviewed on 11/07/11 at 8:30 A.M. to be dated 11/4/11. In an interview with the Director of Nursing [DoN] on 11/7/11 at 9:05 A.M., she indicated the Staff Development Coordinator was responsible for the posting the daily staffing and was no longer employed by the facility. The DoN further indicated at that time, that the posting should be done daily and it had been missed. In an interview with the Nurse Consultant #1 on 11/7/11 at 6:30 P.M., she indicated there was no specific policy and procedure for the posting the daily staffing information and "we should be following the Federal regulation." 3.1-13(a)		residents were found to be affected by this deficient practice.*The nurse staffing information was posted daily at the front desk.Measures put into place or systemic changes made to ensure the deficient practice does not recur:*The scheduler will print out the nurse staffing information each evening and give to the receptionist. The receptionist will post those hours each morning. The weekend posting will be posted seperately for each day on Friday by the receptionist.Corrective actions will be monitored to ensure the deficient practice will not recur:*Administrator/designee will check postings every morning Monday through Friday.*Weekend Managers will ensure nurse staffing is posted and accurate on weekends.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure menus were followed, for 2 of 2 sampled residents [Resident #62, Resident #80], in the sample of 19, and 11 of 11 supplemental sample residents [Resident #22, Resident #27, Resident #33, Resident #34, Resident #39, Resident #41, Resident #42, Resident #43, Resident #56, Resident #72, Resident #83), in the supplemental sample of 15, for two meal services reviewed for pureed diets. The recipe for pureed food was not followed and/or the menued amounts were not served. Findings include: 1. Cook #1 was observed on 11/7/11 at 10:40 A.M., to make egg salad sandwiches for lunch for the residents who required a pureed diet. Cook #1 indicated at that time that the regular supply of biscuit mix was not available, so she would have to use bread crumbs and water in its place. She further indicated there were 15 residents with pureed diet orders. She pureed the food using the recipe and amounts for 15 servings and placed the mixture in a full	F0363	F363Corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*Dietary staff inserviced on procedure for following pureed recipes on 11/18/11.*Dietary manager will observe preparation of one pureed recipe 5 days a week.*When substitute ingredients are necessary, the dietary manager/designee will make the adjustment on the substitution sheet.Residents identified having potential to be affected by the same deficient practice and corrective action taken:*Residents that are on a pureed diet have the potential to be affected. *The Dietary manager has observed the preparation of the pureed food daily, Monday through Friday, to ensure the recipees are being followed.Measures put into place or systemic changes made to ensure deficient practice does not recur:*Dietary staff inserviced on procedure for following recipes on 11/18/11.*Dietary manager/designee will observe preparation of one pureed recipe 5 days a week.*Dietary manager/designee will document the accuracy of puree preparation.Corrective actions will	12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	size steam table pan. The Certified Dietary Manager provided a list of residents on pureed diets on 11/7/11 at 1:11 p.m. The list identified the following residents: Resident #62, Resident #80, Resident #22, Resident #27, Resident #33, Resident #34, Resident #39, Resident #41, Resident #42, Resident #43, Resident #56, Resident #72, Resident #83. On 11/7/11 from 11:45 A.M. -1:15 P.M., the noon meal service was observed continuously. During the observation, the pureed egg salad sandwiches were observed in a large pan on the serving line. The sandwiches had been divided into 24 servings and appeared runny. During the meal service, Cook #1 was observed to serve the sandwiches by scooping up a single divided serving with a spatula and letting it run onto the plate. She was then observed to scoop up more of the egg salad sandwich mixture and let it run onto the plate. She was observed to repeat this practice for each of the residents who received pureed egg salad sandwiches for lunch. At the end of the meal service, the pan of pureed egg salad sandwiches was observed to have approximately 1/3 of the pan with pureed egg salad remaining.		be monitored to ensure the deficient practice will not recur:* A CQI tool for following pureed recipees will be utilized by the dietary manager/designeee 5 days a week.*Results of the audits will be reviewed by the Interdisiplinary Team weekly and monthly by the CQI committee. If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview at that time Cook #1 indicated the reason there were leftovers was, "We didn't use the regular recipe." The recipe for Pureed Egg Salad Sandwiches provided by the CDM [Certified Dietary Manager] 11/7/11 at 3:40 P.M. indicated for 15 servings, "...Bib Pureed Bread and Biscuit Mix...2 1/4/cup..." 2. Cook #2 was observed on 11/7/11 at 3:15 P.M. to make pureed Russian Chicken for supper. During an interview at that time, Cook #2 indicated she needed to prepare 15 servings, but liked to make a little extra just in case. Cook #2 was observed at that time to place 17 chicken breasts into the blender. The cook made no other adjustments to the recipe except for the addition of the chicken breasts. The recipe for Russian Chicken provided by the CDM [Certified Dietary Manager] on 11/7/11 at 3:40 P.M., indicated for 15 servings of pureed Russian Chicken "...15 Russian Chicken..." 3.1-20(i)(4)			